U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 07 November 2003

Case No. 2002-BLA-5235

In the Matter of:
GREGORY JEROME HURLEY,
Claimant,

v.

TCH COAL COMPANY,
Employer,
and
Self-Insured through A.T. MASSEY,
c/o ACORDIA EMPLOYERS SERVICE,

and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
William Lawrence Roberts, Esq.
On behalf of Claimant

Martin E. Hall, Esq.
Natalee Gilmore, Esq.
On behalf of Employer/Carrier

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1]The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On June 14, 2002, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 27).[2] A formal hearing on this matter was conducted on April 16, 2003, in Pikeville, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES

The issues in this case are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled;

4. Whether the Miner's disability is due to pneumoconiosis; and

5. Whether the evidence establishes a material change in condition under § 725.309.

(DX 27). Employer contested additional issues as raised in their May 7, 2001 letter for appellate purposes. At the hearing, Employer withdrew as contested issues the issue of whether miner worked at least fifteen years in coal mine employment and the issue of whether miner has one dependent for purposes of augmentation.

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Gregory Hurley ("Claimant") was born on December 24, 1951; he was fifty-two years old at the time of the hearing. (DX 1). He has earned his G.E.D. (DX 1). On August 15, 1970, he married Judy (Kinney) Hurley; at the time of the hearing they had been married for thirty-two years. (DX 1; Tr. 24). Mrs. Hurley gave birth to Gregory Hurley on May 11, 1981. (DX 1). The parties stipulated that Claimant has one dependent for purposes of augmentation. Over the

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr" refers to the official transcript of this proceeding.

course of his coal mine employment, he was an equipment operator, foreman, and roof bolter. (DX 1). He last engaged in coal mine employment in August 1985, stopping after he sustained a back injury while operating a roof bolting machine. (DX 1). He was last employed as a roof bolter, which also involved operating some machinery and general inside work. (DX 1). He stated that he had to crawl long distances for eight hours per day and lift fifty to seventy pounds numerous times per day. He also had to carry weights ranging from three to seventy-five pounds numerous times per day.

At the most recent hearing, Claimant testified that he was experiencing breathing problems and shortness of breath, for which Dr. Sundaram had prescribed breathing pills and an inhaler. (Tr. 23).

Procedural History

Claimant filed an initial claim for benefits under the Act on October 13, 1993. (DX 1). After the District Director, Office of Workers' Compensation Programs ("OWCP") denied his application in March 1994, Claimant requested a formal hearing. Administrative Law Judge Daniel Leland held a formal hearing in October 1995 and issued a decision and order – denial of benefits on April 23, 1996. Administrative Law Judge Leland found that Claimant engaged in fifteen years of coal mine employment. However, he denied benefits after finding that Claimant failed to establish the presence of pneumoconiosis or a totally disabling respiratory or pulmonary impairment. The Benefits Review Board affirmed Administrative Law Judge Leland's denial in a decision and order dated September 11, 1996.

Claimant filed a subsequent claim for benefits on February 20, 2001. (DX 3). On March 20, 2002, the OWCP issued a proposed decision and order denial of benefits. Claimant requested an informal conference and a formal hearing on March 26, 2002. (DX 22). On June 14, 2002, the OWCP transferred Claimant's claim to the Office of the Administrative Law Judges for a formal hearing. (DX 27).

Length of Coal Mine Employment

Claimant was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties stipulated that Claimant engaged in fifteen years of coal mine employment. This stipulation is supported by the evidence of the record. Therefore, I find that Claimant engaged in fifteen years of coal mine employment.

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified TCH Coal Company as the putative responsible operator. (DX 16). TCH Coal Company did not contest its status as the employer with whom Claimant spent his last cumulative one year period of coal mine employment. Based on the evidence of record, I find that TCH Coal Company is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. § 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or paragraph § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

At the hearing, Claimant submitted the July 22, 2001 report of Dr. Sundaram as Claimant's Exhibit 1. (Tr. 8). Claimant submitted the February 24, 2002 report of Dr. Sarg as Claimant's Exhibit 2. Claimant's designation of medical evidence form was submitted as Claimant's Exhibit 3. Employer objected to the admission of CX 1 and CX 2 on the basis that they exceed the medical evidence limitations. The undersigned reserved ruling on Employer's objection. (Tr. 10). Employer offered eleven exhibits, including Employer Exhibits 9, 10, and 11 which were to be reserved for three depositions Employer requested to submit post-hearing. (Tr. 13). Employer also requested time to submit re-readings of chest x-rays as rebuttal evidence of x-rays dated August 28, 2001 and October 29, 2001. (Tr. 13). The undersigned reserved ruling on the admissibility of all of the exhibits offered by Employer and directed the parties to address the admissibility of evidence in their post-hearing briefs. (Tr. 14). Employer offered an alternative designation of medical evidence should the undersigned find its current designation improper.[3] (Tr. 16). The undersigned granted Employer's request to submit the chest x-ray re-readings post-hearing; their admissibility would then be addressed. (Tr. 19).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 3). He designated the x-ray interpretation rendered by Dr. Simpao on October 29, 2001 as his first chest x-ray and the August 28, 2001 x-ray interpretation of Dr. Sundaram as his second. He offered the October 29, 2001 and August 28, 2001 pulmonary function tests. Claimant only offered one arterial blood gas study, which was dated October 29, 2001. He designated the medical reports of Dr. Simpao dated January 25, 2002 and Dr. Sundaram dated August 28, 2001. Additionally,

[3] Employer stated that if the x-ray interpretations that it designated as its two affirmative chest x-rays were found to be inadmissible because the narrative reports of Drs. Dahhan and Jarboe contained chest x-ray interpretations, then Employer asked that the chest x-ray interpretations of Drs. Dahhan and Jarboe be substituted. (Tr. 16, 17).

as previously noted, Claimant offered the medical reports of Dr. Sundaram dated July 22, 2002 (CX 1) and the report of Dr. Sarg dated February 24, 2003 (CX 2).

Employer also completed a Black Lung Benefits Act Evidence Summary Form. (DX 12). Employer designated the chest x-ray interpretations of Drs. Wheeler and Wiot from x-rays dated September 23, 2002 and July 28, 2001 respectively. Employer designated pulmonary function tests performed by Dr. Dahhan on July 28, 2001 and Dr. Jarboe on September 23, 2001. The only arterial blood gas study offered by Employer was performed by Dr. Dahhan on July 28, 2001. Employer designated the medical reports of Drs. Dahhan and Jarboe dated July 31, 2001 and October 7, 2002 respectively. Employer designated the March 21, 2003 reports of Dr. Fino as rebuttal evidence to the pulmonary function tests designated by Claimant. Additionally, Employer designated the records from Pikeville Methodist Hospital as hospitalization and treatment records. Employer also designated the April 9, 2003 deposition of Dr. Rasmussen as "cross-examination" evidence. Employer submitted a bound copy of eleven exhibits which contained: (1) Dr. Wiot's interpretation of a July 17, 2001 chest x-ray, and Dr. Sptiz's interpretations of x-rays dated July 17, 2001 and July 28, 2001; (2) Pikeville Hospital records; (3) Lexington Clinic chest x-ray dated October 8, 2002; (4) Dr. Wheeler's interpretation of a September 23, 2002 x-ray and Dr. Scott's interpretation of a September 23, 2002 x-ray; (5) and October 7, 2002 narrative medical report of Dr. Jarboe containing a chest x-ray interpretation of Dr. Jarboe, a pulmonary function test performed by Dr. Jarboe, Dr. Simpao's October 29, 2001 x-ray interpretation, Dr. Sundaram's August 28, 2001 x-ray interpretation, x-ray interpretations by Dr. Wiot and Dr. Spitz from July 17, 2001 and July 28, 2001, the x-ray interpretations of Drs. Sundaram, Grimes, Barrett, and Sargent from a November 30, 1993 x-ray, a July 17, 2001 pulmonary function test conducted by Dr. Rasmussen, and the undated medical report of Dr. Anderson. Attached to Dr. Jarboe's report was a document he referenced in his report entitled "Medical Record Review," which contains a review of all of the medical evidence contained in Claimant's prior claim for benefits.; (6) Dr. Wiot's interpretation of a chest x-ray dated September 23, 2002; (7) Dr. Fino's opinion regarding the validity of pulmonary function tests dated August 28, 2001 and October 29, 2001; (8) the March 24, 2003 consultative medical report of Dr. Branscomb that contains Dr. Branscomb's review of all of the medical evidence, including the evidence submitted in Claimant's prior claim; (9) the transcript of the April 9, 2003 deposition of Dr. Jarboe; (10) the n transcript of the "rebuttal" deposition of Dr. Rasmussen dated April 9, 2003; and (11) the deposition transcript of Dr. Dahhan dated April 14, 2003.

The Director's Exhibits as transferred to the undersigned contain the following items of medical evidence submitted in Claimant's subsequent claim: (1) the October 4, 1995 opinion of Dr. Sundaram (DX 9); (2) the July 31, 2001 examination report of Dr. Dahhan, which contains a chest x-ray, pulmonary function test, and an arterial blood gas study (DX 10); (3) the August 28, 2001 examination form completed by Dr. Sundaram containing a chest x-ray, pulmonary function test, and arterial blood gas study (DX 11); (4) the October 29, 2001 examination report of Dr. Simpao containing a chest x-ray, pulmonary function test, arterial blood gas study, with the October 29, 2001 x-ray interpretation of Dr. Armstrong attached but not referred to in his report (DX 12); (5) a quality-only x-ray interpretation rendered by Dr. Sargent of a July 17, 2001 x-ray obtained by the OWCP (DX 13); (6) the chest x-ray interpretation of Dr. Patel dated July 17, 2001 obtained by the OWCP (DX 13); (7) the July 17, 2001 examination form completed by Dr. Rasmussen containing a reference to Dr. Patel's chest x-ray interpretation, pulmonary

function test, arterial blood gas study, and narrative report obtained by the OWCP (DX 13); and (8) Dr. Wiot's chest x-ray interpretation of a film dated July 28, 2001 (DX 14).

The evidence designated by Claimant complies with the limitations found at § 725.414(a)(2)(1). According to Complainant's Exhibit 3, he designated the medical report of Dr. Simpao dated January 25, 2002. After reviewing all documents contained in the record, the undersigned was unable to find a report issued by Dr. Simpao on January 25, 2002. On December 9, 2002, Claimant submitted "full and supplemental reports, " which were prepared by Dr. Simpao. The "full" report is dated October 29, 2001. The last page attached to Claimant's December 9, 2002 letter is an examining physician form completed by Dr. Simpao and dated November 20 , 2002.

In his post-hearing brief, Claimant summarized the findings rendered by Dr. Simpao in his October 29, 2001 medical report. Claimant also summarized the findings and conclusions rendered by Dr. Simpao on the examining physician form completed by Dr. Simpao on November 20, 2002. The provisions limiting the submission of affirmative medical evidence under § 725.414 do not expressly provide for a supplemental, affirmative opinion. Dr. Simpao completed the two reports over a year apart. The November 20, 2002 form does not contain a reference to any specific piece of evidence; it only contains generic references to the findings of x-rays, PFTs, ABGs, and a clinical examination. If the November 20, 2002 report were admitted as Claimant's second affirmative narrative opinion, the undersigned would not attribute probative weight to the form because it does not identify what examination, x-ray, PFT, or ABG it relies upon; the undersigned would not be able to determine if it is a reasoned and documented opinion. Moreover, the November 20, 2002 form does not constitute rebuttal or rehabilitative evidence. Thus, the undersigned will admit the October 29, 2001 report of Dr. Simpao as Claimant's second affirmative medical report. Therefore, Director's Exhibits 11 and 12, which contain the examination reports of Drs. Simpao from October 29, 2001 and Dr. Sundaram from August 28, 2001, are admitted into the record of Claimant's subsequent claim. The November 20, 2002 form completed by Dr. Simpao is excluded.

The form submitted by Claimant as CX 1 is a form signed by Dr. Sundaram as Claimant's treating physician on July 22, 2002 providing a narrative opinion on Claimant's cardiorespiratory system. It does not contain a reference to any specific piece of evidence. It does not indicate that it was created for the purposes of treating any cardiorespiratory symptom and it is not a hospital record. Dr. Sundaram's July 22, 2002 narrative opinion exceeds the limitation found at § 725.414(a)(2)(i). It is not rebuttal or rehabilitative evidence, nor is a hospital or treatment record. Therefore, CX 1 is excluded from the record.

The form completed by Dr. Sarg, which he signed as Claimant's treating physician on February 24, 2003, and offered by Claimant as CX 2 is identical to the form completed by Dr. Sundaram on July 22, 2002. It does not contain any reference to a specific item of medical evidence. It is not a treatment or hospital record. Dr. Sarg's February 24, 2003 narrative opinion exceeds the limitations found at § 725.414(a)(2)(i). Therefore, CX 2 is excluded from the record.

Claimant argues that Dr. Sundaram's narrative report dated July 22, 2002 and Dr. Sarg's report dated February 24, 2003 should not be counted as additional reports. Rather, Claimant argues that they are merely clarifications of the on-going treatment of Claimant by his family and treating physician. (Claimant's Post-Hearing Brief, p. 13, 14). Claimant argues in the alternative, should the undersigned find that the three reports do not count as one report, that he maintains the designation of Dr. Sundaram's August 28, 2001 report as affirmative evidence and then seeks to offer the subsequent narrative reports of Drs. Sundaram and Sarg as "rehabilitative medical evidence in rebuttal of the medical reports submitted by the Defendant-Employer." *Id.* Since the July 22, 2002 and February 24, 2003 reports are narrative opinions, not treatment records, they constitute separate narrative medical reports, which I have determined exceed the limitations on affirmative evidence that may be offered by Claimant. Claimant does not identify any provision of 20 C.F.R. Parts 718 or 725 that would support such a construction, nor does Claimant provide and case law to support his argument. Therefore, I decline to adopt Claimant's argument to construe three reports from two physicians as one narrative medical opinion. The July 22, 2002 and February 24, 2003 reports of Drs. Sundaram and Sarg are not admissible as rebuttal or rehabilitative evidence, whichever way Claimant's argument is interpreted, because they do not specifically rebut any affirmative evidence offered by Employer, nor do they constitute rehabilitative evidence because the July 22, 2002 report of Dr. Sundaram does not explain his conclusion in light of the rebuttal evidence offered against his August 28, 2001 report and Dr. Sarg did not previously issue a report that could have been the subject of rebuttal evidence for him to rehabilitate. Again, CX 1 and CX 2 are excluded from the record.

I also exclude the x-ray interpretation of Sherri Armstrong, M.D. (DX 12) of an x-ray dated October 29, 2001 because it exceeds the limitations on affirmative evidence under § 725.414(a)(2)(i).

Regarding the evidence offered by Employer, since the designated medical reports of Drs. Dahhan and Jarboe contain chest x-ray interpretations that would be inadmissible if the x-ray interpretations of Drs. Wheeler and Wiot were admitted as Employer's two affirmative x-rays, I will analyze Employer's designation of medical evidence based on the alternative designation Employer offered at the hearing.[45] I admit into the record of Claimant's subsequent claim, based on Employer's designations, the July 31, 2001 narrative report of Dr. Dahhan containing a chest x-ray interpretation, pulmonary function test, and arterial blood gas study. I also admit Dr. Jarboe's x-ray interpretation and pulmonary function test, but I exclude the narrative report of Dr. Jarboe dated September 23, 2002 because it contains chest x-rays and narrative medical reports that are not admissible under § 725.414(a)(3)(i). I exclude the x-ray interpretation of Dr. Spitz from the x-ray dated July 28, 2001, since it exceeds the limitations on affirmative evidence under § 725.414(a)(3)(ii). Dr. Spitz's interpretation of Dr. Patel's July 17, 2001 x-ray is admitted as rebuttal evidence under § 725.414(a)(3)(ii). I exclude the x-ray interpretation of Dr. Wiot from the x-ray dated July 17, 2001, since it exceeds the limitation on affirmative evidence found at § 725.414(a)(3)(i).

[4] Since this case arose during an early stage of the implementation of the amended provisions of § 725.414, the undersigned allowed Employer to make an alternate designation. However, the undersigned does not and will not adopt a policy of allowing parties to make alternate designation in future cases.

Employer's exhibits 2 and 3 are admitted as hospital and treatment records under § 725.414(a)(4). I exclude the x-ray interpretations of Drs. Wheeler, Wiot, and Scott from an x-ray dated September 23, 2002 since they exceed the limitations on affirmative evidence under § 725.414(a)(3)(i). The March 21, 2003 report of Dr. Fino is admitted as rebuttal evidence of the affirmative pulmonary function tests admitted by Claimant under § 725.414(a)(3(ii). I exclude the March 24, 2003 report of Dr. Branscomb since it exceeds the limitation on affirmative evidence under § 725.414(a)(3)(i) and because it contains evidence that is not admissible under § 725.414(a)(3)(i). I exclude the transcript of Dr. Jarboe's deposition dated April 9, 2003 since it is based on his narrative opinion that is excluded and because it contains medical evidence that is not admissible under § 725.414(a)(3)(i). Since I admitted Dr. Rasmussen's July 17, 2002 report, the deposition testimony of Dr. Rasmussen submitted as EX 10 is admitted under § 725.414(c). However, I exclude pages 9 line, 14 through page 12, line 18 because it contains a section of Dr. Branscomb's report that was excluded. Since Dr. Dahhan's July 31, 2002 report was admitted under § 725.414(a)(3)(i), his deposition dated April 14, 2003 is admitted under § 725.414(c). However, since Dr. Dahhan's deposition testimony after page 17, line 18 contains medical evidence not admissible under § 725.414, I exclude Dr. Dahhan's deposition from page 17, line 19 until the end. I admit Employer's post-hearing submission of chest x-ray interpretations of Dr. Wiot of x-rays dated August 28, 2001 and October 29, 2001 as rebuttal evidence under § 725.414(a)(3(ii).

X-RAY REPORTS

Exhibit	**Date of X-ray**	**Date of Reading**	**Physician/Qualifications**	**Interpretation**
DX 13	7/17/01	07/20/01	Patel, BCR, B-reader	0/1
DX 13	7/17/01	10/04/01	Sargent, BCR[5][2], B-reader[6][3]	Quality one
EX 1	7/17/01	11/15/01	Spitz, BCR, B-reader	negative
DX 10	7/28/01	07/28/01	Dahhan, B-reader	negative
DX 11	8/28/01	08/28/01	Sundaram	1/1
EX 13	8/28/01	04/29/03	Wiot, BCR, B-reader	Negative

5A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[6]A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

DX 12	10/29/01	10/29/01	Simpao	1/2
EX 13	10/29/01	4/29/03	Wiot, BCR, B-reader	negative
EX 5	9/23/02	9/23/02	Jarboe, B-reader	negative
EX 4	10/8/02	10/8/02	Guy	negative

PULMONARY FUNCTION STUDIES

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 13 7/17/01	Good/ Good/ Yes	49 68"[74]	2.95	3.93	94	75%	No
DX 10 7/28/01	Fair/ Good/ Yes	49 166cm	2.85	3.79	47.64[86]	75%	No
DX 11 8/28/01	Good/ Good/ Yes	49 68”	2.33	3.22		72%	No
DX 12[97] 10/29/01	/ / Yes	49 67”	2.56	3.52	76	73%	No
EX 5[108] 9/23/02	Fair/ Fair/ Yes	50 173cm	2.25 2.60*	3.07 3.42*	73% 76%*	83 79*	No No

*post-bronchodilator values

[7] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find that the miner’s actual height is 68 inches.

8Dr. Dahhan stated that the MVV was invalid due to poor effort.
9 Dr. Simpao commented that the spirometry data is acceptable and reproducible.
10 Dr. Jarboe’s final impression from the spirogram was that is suggests a mild restrictive and obstructive ventilatory defect, which essentially clears following dilators. He noted that Claimant’s carbon monoxide level was compatible with that of a nonsmoker.

ARTERIAL BLOOD GASES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 13	7/17/01	37 37*	85 87*	No No
DX 10	7/28/01	39.1	83.6	No
DX 12	10/29/01	35.5	82.7	No

*Results obtained with exercise

Narrative Medical Evidence

On July 17, 2001, Dennis Rasmussen, M.D., who is board-certified in internal medicine, examined Claimant and completed a Department of Labor Medical History and Examination for Coal Workers' Pneumoconiosis form. He noted sixteen year history of coal mine employment as an equipment operator and roof bolter. He considered a smoking history of one-half pack of cigarettes per day from 1967 ending in 1976. Claimant complained of sputum, wheezing, dyspnea, cough, hemoptysis, chest pain, orthopnea, and ankle edema. Upon auscultation, Dr. Rasmussen detected normal breath sounds. He submitted Claimant to a chest x-ray, pulmonary function test ("PFT"), arterial blood gas study ("ABG"), and an EKG. He reviewed the negative interpretation of the chest x-ray, and found the results of the PFT and ABG to be normal. Dr. Rasmussen's cardiopulmonary diagnosis was "CWP – chronic productive cough." He opined that the etiology of his cardiopulmonary diagnosis was "chronic bronchitis – coal dust exposure." He noted that Claimant exhibits poor exercise tolerance but has normal lung function. Dr. Rasmussen found that Claimant retains the respiratory capacity to perform his regular coal mine job. Dr. Rasmussen added a narrative report to the form he completed. He recounted Claimant's complaints and provided a detailed account of the exertional requirements of Claimant's usual coal mine employment. He noted that Dr. Patel's chest x-ray interpretation was 0/1, and documented that the PFT and ABG were normal. He opined, after submitting Claimant to an incremental treadmill test, that Claimant's studies indicate poor tolerance to exercise, but normal lung function. Again, he opined that Claimant retained the respiratory capacity to perform his regular coal mine work. He noted that Claimant has a significant history of exposure to coal mine dust, however he has insufficient x-ray changes to justify a diagnosis of CWP. He concluded that a diagnosis of CWP cannot be established in this case. Lastly, Dr. Rasmussen stated that Claimant's coal dust exposure has produced no measurable loss of lung function. Dr. Rasmussen completed another form, answering that Claimant does not have an occupational lung disease caused by coal mine employment. He stated that Claimant has no pulmonary impairment. He concluded that Claimant retained the respiratory capacity to perform his usual coal mine employment or comparable work in a dust-free environment.

Abdul Dahhan, M.D., who is board-certified in internal medicine and the subspecialty of internal disease, examined Miner on July 28, 2001 and provided a narrative report on July 31, 2001. He noted a sixteen year history of coal mining and history of being a tobacco chewer with

a history of smoking only in his teens. Claimant complained of a daily cough with sputum, occasional wheeze, and dyspnea on exertion. Clinical examination of Claimant's lungs revealed good air entry into both lungs. Dr. Dahhan interpreted a chest x-ray as negative and conducted a PFT, ABG, and EKG. He found the PFT to show, overall, normal respiratory mechanics and no evidence of a restrictive or obstructive disease. Dr. Dahhan interpreted the ABG as revealing normal values at rest. The EKG was normal. Dr. Dahhan opined, based on his examination of Claimant, that there is insufficient objective data to justify the diagnosis of CWP because there was normal clinical examination of the chest, normal PFT (including lung volumes, spirometry, and diffusion capacity), normal ABG at rest, and clear chest x-ray. He found no objective findings to indicate any pulmonary impairment or disability as demonstrated by normal clinical and physiological parameters. Dr. Dahhan, from a respiratory standpoint, opined that Claimant retains the respiratory capacity to perform his previous coal mine employment or job of comparable physical demand since he has no objective findings of any pulmonary impairment. Moreover, Dr. Dahhan found no evidence of any pulmonary impairment or disability caused by, contributed to, or aggravated by the inhalation of coal dust or CWP since his entire pulmonary evaluation shows no abnormalities.

Raghu Sundaram, M.D., examined Miner on August 28, 2001 and completed a Department of Labor Medical History and Examination for Coal Workers' Pneumoconiosis form. He detected rhonchi and wheezes upon clinical examination of Claimant's lungs. He did not provide an account of Claimant's coal mine employment or smoking histories. He performed a PFT. Dr. Sundaram stated a cardiorespiratory diagnosis of CWP due to prolonged exposure to coal dust. He found that Claimant was suffering from a Class III impairment under the AMA guidelines. Dr. Sundaram attributed 25-35% of Miner's impairment to his CWP based on AMA guidelines. Dr. Sundaram attached an additional form, on which he answered that Claimant has an occupational lung disease caused by coal mine employment based on seventeen-and-one-half years of underground mining. He assessed Claimant's pulmonary impairment as severe and attributed the entire impairment to pneumoconiosis because Claimant never smoked. He opined that Claimant does not have the respiratory capacity to perform the work of a coal miner or comparable gainful work due to shortness of breath with limited activity.

Valentino Simpao, M.D. examined Claimant on October 29, 2001 and prepared a narrative report. He considered a coal mine employment history of seventeen years as an equipment operator and a smoking history that lasted for a very short time as a teenager. Claimant complained of a productive cough and shortness of breath. He detected a few crepitations and slight wheezes both inspiratory and expiratory. Dr. Simpao interpreted a chest x-ray as positive for CWP. He conducted a PFT that he determined showed a mild degree of restrictive and moderate degree of obstructive airway disease. He interpreted the results of an ABG to show a ventilatory perfusion mismatch. An EKG was normal.

On March 21, 2003, Gregory Fino, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, issued a narrative opinion after reviewing the values and tracings from the pulmonary function tests performed on August 28, 2001 and October 29, 2001. (EX 7). Dr. Fino opined that both spirometries, as well as the MVV value from the October 29, 2001 PFT were invalid. He stated that they both underestimate Claimant's true pulmonary function.

Dr. Rasmussen was deposed on April 9, 2003. Dr. Rasmussen reiterated the findings and conclusions contained in his July 17, 2001 report. He stated that Claimant's symptoms may be consistent with early asthma or COPD based on a history of wheezing with exposure to hairsprays and perfumes. Dr. Rasmussen testified that his stated diagnosis of CWP on page 4 of his July 17, 2001 report was a typographical error that was supposed to have been a diagnosis chronic bronchitis. He attributed Claimant's poor exercise tolerance to poor physical conditions, not coal dust exposure. Dr. Rasmussen reiterated his finding that Claimant's chronic bronchitis could have been caused by coal dust exposure, but if Claimant continued to smoke until 1998 or 1999, then he would find smoking to be a co-cause of Claimant's chronic bronchitis. He stated that he did not diagnose legal pneumoconiosis.

Dr. Dahhan was deposed on April 14, 2003. Dr. Dahhan, through page seventeen of his deposition, reiterated the findings and conclusions contained in his July 31, 2001 report.

Hospital Records

Claimant has been hospitalized several times a Pikeville United Methodist Hospital since 1984 when he was treated for burns on his hands. Claimant was admitted in 1985 for a bulging disc at L5-S1. He suffered a right leg injury in 1990, and in 1992 he was treated for a head injury sustained after his home exploded. In 1998 Claimant sustained injuries to his right foot from a lawn mower accident, which led to the disarticulation of some of the toes on Claimant's right foot. While receiving treatment for his right foot in July and September of 1998, Claimant stated that he smoked one to one-and-one-half packs of cigarettes per day. Claimant underwent a cytoscopy and right uteroscopy for kidney stones. In April 2001, while being evaluated in relation to a depression Claimant was suffering, he stated that he and his wife were going out to smoke, but he did not return.

Smoking History

Claimant testified during the previous hearing that he smoked off-and-on over the course of ten to fifteen years, last smoking in 1992. He testified that the cumulative time he smoked would be five years. At the most recent hearing, Claimant testified that the hospital record report noting that he had smoked one-and-one-half packs of cigarettes per day was wrong. (Tr. 25). He testified that he was not presently smoking and that he had never been a regular smoker. (Tr. 25). Claimant offered that his history of being a tobacco chewer may have been misunderstood for tobacco smoking. (Tr. 26). He estimated that the cumulative amount of time that he had been a cigarette smoker might amount to one year or less. (Tr. 26). The hospital records that Claimant testified were wrong document a smoking history of one to one-and-one-half packs of cigarettes per day as recent as 1998. Dr. Dahhan documented a smoking history in Claimant's teens, noting that Claimant was a tobacco chewer. Dr. Rasmussen documented a smoking history from 1967 to 1976. Dr. Jarboe's impression from Claimant's carbon monoxide level in 2003 was that Claimant was a non-smoker. I credit Claimant's testimony that he is presently a non-smoker who chews tobacco. I also credit his testimony that the hospital documentation of a smoking history was erroneous. Therefore, I find that Claimant smoked for a cumulative period of five years in the late 1960s and early 1970s.

DISCUSSION AND APPLICABLE LAW

The claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the "material change in conditions" language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d) (April 1, 2002).

Claimant's prior application for benefits was denied by Administrative Law Judge Leland after he found that Claimant did not establish the presence of pneumoconiosis and that Claimant did not establish the presence of a totally disabling respiratory or pulmonary impairment. Therefore, in order for Claimant to prevent his subsequent claim from being denied on the basis of the prior denial, he must establish the presence of pneumoconiosis or the presence of a totally disabling respiratory or pulmonary impairment through the newly submitted medical evidence.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The newly submitted evidentiary record consists of nine interpretations of six chest x-rays. Two physicians who are dually-certified as radiologists and B-readers interpreted a film dated July 17, 2001 as negative. There were no positive interpretations. Therefore, I find that the film dated July 17, 2001 is negative. Dr. Dahhan, a B-reader, found the film dated July 28, 2001 to be negative. There were no positive interpretations. Therefore, I find that the July 28, 2001 film is negative. Dr. Sundaram found an August 28, 2001 film to be positive for pneumoconiosis, while Dr. Wiot found the film to be negative. I accord greater weight to Dr. Wiot's interpretation based on his credentials as a dually-certified physician. Therefore, I find that he August 28, 2001 film is negative. Dr. Simpao interpreted the film dated October 29, 2001 as positive for pneumoconiosis, while Dr. Wiot found it to be negative. I accord greater weight to Dr. Wiot's interpretation based on his credentials as a dually-certified physician. Therefore, I find that the film dated October 29, 2001 is negative. Dr. Jarboe, a B-reader, found the film dated September 23, 2002 to be negative. There were no positive interpretations. Therefore, I find that the film dated September 23, 2002 is negative. Dr. Guy interpreted a film dated October 8, 2002 as negative. There were no positive interpretations. Therefore, I find that the October 8, 2002 film is negative. I have determined that all six of the newly submitted chest x-rays are negative for the existence of pneumoconiosis. Claimant has failed to establish that the preponderance of the x-ray evidence is positive for the existence of pneumoconiosis. Therefore, I find that the Claimant has not established the existence of pneumoconiosis by x-ray evidence under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The newly submitted evidentiary record does not contain any biopsy evidence to review. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Rasmussen examined Claimant on July 17, 2001 and rendered a narrative report. He provided deposition testimony regarding his examination. Dr. Rasmussen opined that a diagnosis of CWP cannot be established. He found that Claimant had insufficient medical evidence to establish a diagnosis of CWP. Dr. Rasmussen did diagnose chronic bronchitis, which he found to be arising out of Claimant's coal dust exposure. Even though Dr. Rasmussen testified that he understood the definition of pneumoconiosis, he testified that he did not render a diagnosis of legal pneumoconiosis. However, Dr. Rasmussen's diagnosis of chronic bronchitis arising out of coal dust exposure amounts to a diagnosis of legal pneumoconiosis. On another form, Dr. Rasmussen found that Claimant did not have an occupational lung disease arising out of his coal mine employment. Dr. Rasmussen submitted Claimant to objective testing, he noted Claimant's subjective complaints, and he performed a clinical examination. He considered an accurate account of Claimant's smoking and coal mine employment histories. Dr. Rasmussen set forth clinical observations and findings, but the forms he completed and his deposition testimony are inconsistent and conflicting. Therefore, I find that Dr. Rasmussen's opinion is entitled to a lesser degree of probative weight.

Dr. Dahhan examined Claimant and issued a narrative report in July 2001. He opined that there is insufficient objective data to diagnose pneumoconiosis based on his normal clinical examination of Claimant's chest, normal PFT and ABG values at rest, and a negative chest x-ray. Dr. Dahhan conducted a clinical examination and noted Claimant's subjective complaints. He considered an accurate account of Claimant's smoking and coal mine employment histories. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Dahhan's opinion is entitled to probative weigh enhanced by his credentials as a board-certified pulmonologist.

Dr. Sundaram examined Claimant and issued a narrative report in August 2001. He diagnosed CWP due to a prolonged history of coal dust exposure. On an additional form, Dr. Sundaram diagnosed CWP based on seventeen-and-one-half years of underground mining. He also found that Claimant suffers from a severe pulmonary impairment that he attributed to coal dust exposure because Claimant never smoked. Dr. Sundaram conducted a clinical examination and submitted Claimant to objective testing. However, he did not consider an accurate account of Claimant's smoking history. The Sixth Circuit Court of Appeals has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). The Board has also explained that, when a doctor relies solely on a chest x-ray and coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Taylor v. Brown Bodgett, Inc.*, 8 B.L.R. 1-405 (1985). *See also Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989)(it is permissible to discredit the opinion of a physician which amounts to no more than a restatement of the x-ray reading). Dr. Sundaram's diagnosis of clinical pneumoconiosis based on his x-ray interpretation and Claimant's prolonged history of coal dust exposure does not constitute a reasoned medical opinion under this subsection. Similarly, Dr. Sundaram's diagnosis of legal pneumoconiosis (severe pulmonary impairment due solely to coal dust inhalation) does not constitute a reasoned medical opinion. He did not identify adequate data to support his opinion that Claimant's pulmonary impairment was severe. His rationale attributing the entire impairment to Claimant's coal dust exposure based on his erroneous documentation of Claimant's smoking history is not reliable. Therefore, I find that Dr. Sundaram's August 2001 report does not contain a reasoned medical opinion finding the presence of legal or clinical pneumoconiosis. His report cannot be found to support a finding of legal or clinical pneumoconiosis under this subsection.

Dr. Simpao examined Claimant in October 2001 and prepared a report. He interpreted a chest x-ray as positive for CWP. Dr. Simpao's diagnosis of CWP was based solely on his chest x-ray interpretation. Therefore, Dr. Simpao's diagnosis of clinical pneumoconiosis does not constitute a reasoned medical opinion under this subsection. Through his interpretation of PFT and ABG results, Dr. Simpao found the presence of a restrictive and obstructive airways disease, but he did not provide an opinion as to the etiology of the impairments. Thus, his interpretation finding pulmonary impairments does not constitute a diagnosis of legal pneumoconiosis. Thus, I find that Dr. Simpao's October 2001 report does not contain a reasoned narrative opinion finding the presence of clinical or legal pneumoconiosis. His report cannot support a finding of legal or clinical pneumoconiosis.

The record does not contain a reliable, reasoned medical opinion finding the presence of legal or clinical pneumoconiosis. To the contrary, Dr. Dahhan provided a narrative report entitled to probative weight enhanced by his credentials as a board-certified pulmonologist finding that there was insufficient objective medical evidence to diagnose the presence of pneumoconiosis. Dr. Rasmussen's subsequent testimony that he did not diagnose legal pneumoconiosis, which contradicts the opinion contained in his July 2001 report that constitutes a diagnosis of legal pneumoconiosis, is ambiguous and unreliable. Dr. Sundaram and Dr. Simpao did not provide reasoned medical opinions that can support a finding of pneumoconiosis under this subsection. Therefore, I find that Claimant has failed to establish the presence of legal or clinical pneumoconiosis by a preponderance of the narrative opinion evidence under subsection (a)(4).

Claimant has failed to establish the presence of pneumoconiosis through newly submitted evidence under any applicable subsection of § 718.202(a). Accordingly, Claimant has not yet established an element of entitlement previously adjudicated against him.

Total Disability

Claimant may also establish an element of entitlement previously adjudicated against him by demonstrating that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence, both "like" and "unlike" must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I previously determined that Claimant does not suffer from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. The five newly submitted pulmonary function tests all failed to produce values equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. Therefore, I find that Claimant has failed to establish the presence of total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) by the results of arterial blood gas studies. The three newly submitted arterial blood gas studies did not produce values equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. Therefore, I find that Claimant has failed to establish the presence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Claimant did not present any evidence that he suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the presence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment as a roof bolter and equipment operator involved arduous manual labor that required Claimant to crawl and to lift and carry heavy weight daily.

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability ismade and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Dr. Rasmussen examined Claimant and provided a narrative report in July 2001. He noted that Claimant exhibits poor exercise tolerance, but has normal lung function. Dr. Rasmussen testified that Claimant's poor exercise tolerance was the result of Claimant's poor physical conditioning. He opined that Claimant retained the respiratory capacity to perform his regular coal mine employment. He did not find the presence of any pulmonary impairment. Dr. Rasmussen considered a detailed account of the exertional requirements of Claimant's usual coal mine employment. He submitted Claimant to objective testing, including an incremental treadmill test. He interpreted Claimant's PFT and ABG as normal. Dr. Rasmussen set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Rasmussen's opinion is entitled to probative weight enhanced by his board-certification in internal medicine.

Dr. Dahhan examined Claimant and issued a narrative report in July 2001. He found no objective findings to indicate the presence of any pulmonary impairment or disability as demonstrated by normal clinical and physiological parameters. Dr. Dahhan interpreted the values from a PFT and ABG he submitted Claimant to as normal. He opined that Claimant retains the respiratory capacity to perform his usual coal mine employment or job of comparable physical demand because there is no evidence of any pulmonary impairment or disability. Dr. Dahhan set forth clinical observations and findings, and his reasoning is supported by adequate

data. His opinion is reasoned and documented. I find that Dr. Dahhan's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Sundaram examined Claimant and submitted a narrative report in August 2001. He opined that Claimant was suffering from a Class III impairment under the AMA guidelines. He also opined that Claimant suffered from a severe pulmonary impairment. Dr. Sundaram answered that Claimant did not retain the respiratory capacity to perform the work of a coal miner or comparable gainful work due to shortness of breath with limited activity. Even though Dr. Sundaram performed a clinical examination and submitted Claimant to objective testing, he did not provide any rationale to support his finding of a Class III pulmonary impairment or his finding of a severe pulmonary impairment. Dr. Sundaram's conclusory opinion does not constitute a reasoned opinion for purposes of this subsection. His opinion cannot support a finding of total disability.

Dr. Simpao examined Claimant and submitted a narrative report in October 2001. He interpreted the results of a PFT as revealing a mild degree of restrictive and moderate degree of obstructive airway disease. He found the ABG to reveal a ventilatory perfusion mismatch. Dr. Simpao did not provide an opinion regarding Claimant's ability to perform his usual coal mine employment. I find that Dr. Simpao's interpretations of the PFT and ABG are credible and entitled to probative weight. However, it is notable that Dr. Fino found the values relied upon by Dr. Simpao to be invalid. Dr. Fino also stated that they underestimate Claimant's true pulmonary function.

I find that Claimant has failed to establish the presence of a totally disabling respiratory or pulmonary impairment under subsection (b)(2)(iv). The evidence, including Dr. Jarboe's comments interpreting the September 23, 2002 PFT he conducted and Dr. Simpao's interpretation of the October 29, 2001 PFT and stress-test he conducted, tends to show that Claimant suffers from exercise intolerance and a mild degree of obstructive and restrictive impairment. However, after considering a detailed account of Claimant's coal mine employment, interpreting Claimant's PFT and ABG as normal, and submitting Claimant to an incremental treadmill test, Dr. Rasmussen found that Claimant retained the respiratory capacity to perform his usual coal mine employment. Dr. Rasmussen's opinion is the most probative opinion because he considered the most accurate of Claimant's coal mine employment and because his opinion is based upon more objective data than the other opinions. Dr. Dahhan also found that Claimant retains the respiratory capacity to perform his usual coal mine employment based on his normal clinical examination and normal physiological parameters. The combined weight of the opinions of Drs. Rasmussen and Dahhan, based on the quality of their reasoning and their credentials, establishes that Claimant retains the respiratory capacity to perform his usual coal mine employment. The record does not contain sufficient evidence to establish that Claimant's mild restrictive and mild obstructive airways disease prevents him from performing his usual coal mine employment, even though his usual coal mine employment involves arduous manual labor. Therefore, I find that Claimant has failed to establish the presence of a totally disabling respiratory or pulmonary impairment under subsection (b)(2)(iv).

Claimant has not established the existence of a totally disabling respiratory or pulmonary impairment under any applicable subsection of § 718.204(b), nor the irrebuttable presumption of § 718.304. Therefore, I find that Claimant is not totally disabled due to a respiratory or pulmonary impairment.

Entitlement

Claimant, Gregory Hurley, has failed to prove, by a preponderance of the evidence, an element of entitlement previously adjudicated against him. Therefore, Mr. Hurley's subsequent claim must be denied on the basis of the prior decision and order – denial of benefits. Gregory Hurley is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the subsequent claim of Gregory Hurley for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**